

DERMATOLOGY MEDICAL HISTORY FORM

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Internal diseases and medication side effects can manifest themselves on the skin. Therefore, it is important to identify your other medical conditions, medications and allergies to medications. Please complete this form to the best of your knowledge.

·	gist? No Yes: Dr
Which pharmacy do you prefer?	
General Medical History:	
Have you ever been PERSONALLY diagnosed well Heart disease Heart murmurs Arrhythmia Bleeding disorder (explain below) Artificial heart valves Pacemaker with defibrillator Pacemaker without defibrillator High blood pressure High cholesterol Diabetes (high blood sugar) Artificial joints Kidney disease, dialysis Hepatitis (what type B or C) or other liver disease (explain below) Organ transplant (what type) AIDS or HIV	with any of the following? Abnormal scars or keloids Abnormal/atypical moles removed from skin Non-melanoma skin cancer (basal cell cancer or squamous cell cancer) Melanoma skin cancer (date, body area, stage, lymph nodes removed? Explain below.) Herpes (circle: genital or mouth) Psoriasis Rheumatoid arthritis Lupus, dermatomyositis or other autoimmune disease (Explain below.) Intravenous drug use Emphysema or COPD Asthma Hay fever (allergic rhinitis), environmental allergies
Use this space for explanations AND other med	lical conditions (PLEASE PRINT):
Conoral Surgical History (DI EASE DDINT).	
General Surgical History (PLEASE PRINT):	
Female patients:	

Are you breastfeeding now?

Y N

Are you pregnant now, or plan to be pregnant soon?



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Family History:		Social	Social History:			
Is a blood relative affected by any of	the following?					
☐ Adopted, family history unknown		Do y	ou use alcohol?	Υ	1	
 □ Basal Cell □ Squamous Cell □ Melanoma Which relative: □ Psoriasis □ Lupus □ Rheumatoid Arthritis □ Thyroid disease 		Do yo	Do you use caffeine?		1	
			Have you used any tobacco products in the past 30 days?		1	
Which relative:		Are y	ou a former smoker?	Υ	1	
☐ Allergies, Asthma, Eczema		If so,	what year did you quit:			
Which relative:			ou have concerns about your	Υ	1	
		safet	y? anyone hurt you in any way?	Υ	Ν	
			,,,,,,, .		-	
Allergies to medication (check b	oox if allergic AND list rea	ction):				
☐ Lidocaine, reaction:	_ Penicillin, reaction:		☐ Creams/Ointments, list name a	nd rea	actic	
☐ Epinephrine, reaction:	_ □ Sulfa, reaction:					
☐ Betadine/Iodine, reaction:	_ ☐ Other antibiotics, list nar	ne and reaction:				
□ Codeine, Morphine, Narcotics reaction:						
Medications (Check box and use ☐ Aspirin (strength:)	e line for explanations): ☐ Other prescription med	ications (PRII	NT names):			
☐ Arthritis medications					_	
(list:)					_	
☐ Coumadin/Warfarin					_	
□ Plavix					_	
☐ Other blood thinners (list:	☐ Over-the-counter medications, supplements (PRINT names):					
)					_	
Name of person filling out this form	1		Date			